No. 84-495

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

RICHARD THORNBURGH, *et al.*,

Appellants,

—VS.—

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF AMICI CURIAE OF THE AMERICAN CIVIL LIBERTIES UNION, THE PENNSYLVANIA CIVIL LIBERTIES UNION AND THE ANTI-DEFAMATION LEAGUE

NAN D. HUNTER
JANET BENSHOOF
SUZANNE M. LYNN
VERNA C. SANCHEZ
American Civil Liberties Union Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

Attorneys for *Amici Curiae*

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases: PAGE

PAGE

Miscellaneous:

INTEREST OF *AMICI*

The American Civil Liberties Union (ACLU) is a nationwide, non-partisan organization with more than 200,000 members dedicated to defending the Bill of Rights. The ACLU established the Reproductive Freedom Project in 1974 to protect a woman's fundamental right to privacy and reproductive freedom. The ACLU believes that each woman has a fundamental right to choose to terminate her pregnancy by abortion, guaranteed by her constitutional rights of privacy, equal protection, and religious freedom, and has participated either as *amicus* or party's counsel in every abortion case before this Court.

The Pennsylvania affiliate of the American Civil Liberties Union has throughout the last decade worked to protect the right of women to privacy and reproductive freedom. This affiliate is presently challenging Pennsylvania's Medicaid funding cut-off for abortions and has succeeded in securing a governor's veto of a bill which would have closed the courts to any suit against a doctor for failing to inform the patient of the likely consequence of carrying a pregnancy to term.

The Anti-Defamation League of B'nai B'rith was organized as a section of B'nai B'rith, the oldest civic service organization of American Jews, to advance good will and mutual understanding among Americans of all creeds and races and to secure justice and fair treatment for all. The Anti-Defamation League is vitally interested in protecting the freedom of conscience of all persons and all other freedoms consistent with an open, democratic society. In this spirit, the Anti-Defamation League has previously filed *amicus* briefs in such landmark civil liberties cases as *Brown v. Board of Education*, 347 U.S. 483 (1953), *Sherbert v. Verner*, 374 U.S. 398 (1963), and *Lemon v. Kurtzman*, 403 U.S. 602 (1971).

All parties have given their consent for the filing of this brief in letters filed with the Clerk of this Court.

ARGUMENT

I. THE REQUIREMENTS IMPOSED BY SECTION 3210(B) PERTAINING TO CHOICE OF METHOD AND STANDARD OF CARE FOR THE FETUS WILL JEOPARDIZE THE LIFE AND HEALTH OF WOMEN WHOSE NEED FOR POST-VIABILITY ABORTIONS IS UNQUESTIONED.

A. Post-Viability Abortions Occur In Highly Individualized Situations Involving Serious Health Problems.

The statutory requirements of § 3210(b) of the Pennsylvania Abortion Control Act, 18 Pa. Const. Stat. Ann. §§ 3201-3220 (Purdon 1983) apply only to post-viability abortions which a physician has certified to be necessary for the preservation of the pregnant woman's life or health. As such, their impact is limited in number but enormous in consequence.

Since abortion became legal nationwide in 1973, most women have been able to make their abortion decisions earlier and earlier in pregnancy.[1] Today, 99 percent of all abortions are performed in the first 20 weeks of pregnancy; after 24 weeks, in the realm in which viability becomes possible, only 0.01 percent are performed.[2] There are no data which classify abortions on the basis of viability.[3]

---

1 Grimes, *Second Trimester Abortions in the United States*, 16 Fam. Plan. Persp. 260, 261 (1984).

2 Henshaw, Binkin, Blaine, & Smith, *A Portrait of American Women Who Obtain Abortions*, 17 Fam. Plan. Persp., 90, 91 (1985). Similar statistics are true in Pennsylvania: of 59,258 abortions reported in 1984, only 5 (less than 0.01 per cent) were performed at 27 or more weeks. Pennsylvania Department of Health News Release (June 10, 1985).

3 The data cited, although the most reliable available, do not specify the number of abortions covered by § 3210(b) and similar statutes for two reasons. First, statistics on third-trimester abortions may include fetuses which are not yet viable, no longer viable (as when the fetus has died in utero) or which never were viable (as with anencephalic fetuses). Spitz, Lee, Grimes, Schoenbucher & Lavoie, *Third-Trimester Induced Abortion in Georgia, 1979 and 1980*, 73 Am. J. of Pub. Health 594 (1983). Second, the data may fail to include some terminations of wanted pregnancies, done past the point of viability, which are necessitated by a threat to the woman's health. Although § 3203 of the Pennsylvania statute defines abortion as any termination performed when there is "a reasonable likelihood" (a phrase which is undefined) that the procedure will cause fetal death, this definition conflicts with standard medical definitions of the term abortion. If a fetus is in distress, there may be a reasonable likelihood of fetal death resulting from a cesarean at thirty weeks. But because most physicians would not consider this procedure to be an abortion unless there was also the intent to cause fetal death, it probably would not be included in abortion statistics. *See* J.A. Pritchard, P.C. MacDonald, & N.F. Gant, *Williams Obstetrics* 467 (17th ed. 1985).

Although few in number, post-viability abortions required for life or health typically occur in situations of acute, particularized need. The onset or worsening of such diseases as pre-eclampsia, diabetes, cardiovascular disease, cervical cancer, ovarian cancer, breast cancer, high blood pressure, kidney disease and certain respiratory, urinary and neuromuscular disorders late in pregnancy may present a health risk sufficient to require termination.[4] Conditions of fetal abnormality also account for some late abortions, in part because it is not usually possible to obtain results from amniocentesis tests until after the 20th week of pregnancy.[5] Psychological distress may also reach a level where treatment, which may include abortion, is indicated.[6]

---

4 See generally, S.L. Romney, N.J. Hay, A.B. Little, J.A. Merill, E.J. Quilligan, & R.W. Standler, *Gynecology & Obstetrics*, (2nd ed.1981) at 703, 705-708, 710, 712-714, 718, 722, 724, 726, 729, 732, 739, 756, 762, 764, 776, 778, 783-4, 793, 795. *See also Williams Obstetrics* at 477. One of the leading causes of maternal mortality nationwide, hypertensive states of pregnancy (toxemia) does not appear until the late second trimester. Termination of the pregnancy is recommended for severe cases and these are usually post-viability. *Id.* at 528, 543.

5 Alan Guttmacher Institute, 3 *Public Policy Issue In Brief* 1, 4 (1983), Tietze, *The Public Health Effects of Legal Abortion in the United States*, 16 Fam. Plan. Persp. 26, 27 (1984).

6 *See, e.g., McRae v. Califano*, 491 F. Supp. 630, 675-6 (E.D.N.Y. 1980) *rev'd on other grounds sub nom. Harris v. McRae*, 448 U.S. 297 (1980).

Such conditions as these were precisely the considerations on which this Court based its decision articulating the centrality of the abortion choice to a woman's overall life and health. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

B. Preferring Fetal Life To The Life And Health Of The Woman Violates The Core Principles Of The Privacy Right Recognized In *Roe v. Wade*.

The primary issue before this Court with regard to § 3210(b) centers on interpretation of the phrase "significantly greater." Appellants contend that the word "significantly" is essentially meaningless, that it designates no measure of risk beyond what is conveyed by the word "greater." That argument, however, fails to satisfy the elementary canon of construction that each word in a statute is presumed to have a core of meaning. *Colautti v. Franklin*, 439 U.S. 379, 392 (1979). In this context, "significantly" must be construed to have its plain meaning, which is fatal to the statute's constitutionality.

Section 3210(b) impermissibly subordinates the woman's life or health to the attempt, however futile, to deliver a fetus which will manifest signs of life, however briefly.[7] No limit germane to the woman's well-being exists on this obligation unless the physician can certify that a given method "would present a significantly greater medical risk to the life or health of the pregnant woman."

The Court of Appeals correctly invalidated § 3210(b) on the ground that state actions creating any greater risk to the woman's life or health violate her right of privacy. *Roe v. Wade*, 410 U.S. at 152-153. In the post-viability phase of

7 Live births do not mean that viable infants are being born. A live birth is defined for official statistical purposes in 45 states as a "product of conception, irrespective of the duration of the pregnancy which . . . breathes or shows any other evidence of life such as beating of the heart . . . or definite movement of voluntary muscle." National Office of Vital Statistics DHEW. *International Recommendations in Definitions of Live Birth and Fetal Death*, Washington, D.C. (1950), cited in Grimes at 263. Most live births are of fetuses which do not have the capacity for more than momentary survival. *Id.* at 263, 264.

pregnancy, when the state has a compelling interest in both the woman's health and the potential life of the fetus, this Court repeatedly has made clear that any conflict between those two interests must be resolved in favor of the woman's health. In *Planned Parenthood Assn. of Kansas City v. Ashcroft*, 462 U.S. 476 (1983), four Justices so stated explicitly. *Id.* at 501-502. Two additional Justices relied on an exemption for any situation posing as much as "an increased risk" to the woman's life or health in order to uphold a second physician requirement for post-viability abortions. 462 U.S. at 485 n.8. No theme has been more central to this Court's elucidation of the abortion right than the primacy accorded the maintenance of the woman's life and health. *Roe*, 410 U.S. at 163-4.

The scope of what constitutes health is broadly defined to include "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." *Doe v. Bolton*, 410 U.S. 179, 192 (1973). This principle, too, commands wide support *Roe v. Wade*, 410 U.S. at 207-8 (Burger, C.J., concurring *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 467 (1983) (O'Connor, White and Rehnquist, J.J., dissenting). Health considerations are particularly critical in the third trimester, "when [many] abortions will be emergency operations," *Planned Parenthood Assn. of Kansas City v. Ashcroft*, 462 U.S. at 485, and virtually all are done in circumstances of extreme distress. The exclusion in § 3210(b) of adverse psychological sequelae of live birth from the physician's evaluation of the woman's health needs illustrates the impermissible intent to subvert the woman's life or health which informs the phrase "significantly greater."

The principles of *Roe v. Wade* instruct that every woman needing an abortion has a right to have it performed under "circumstances that insure [her] maximum safety." 410 U.S. at 150. Section 3210(b) deprives women of the maximum safety to which they are entitled by reversing the order of priorities to require use of the method least disadvantageous to the fetus instead of the method least dangerous to the woman. It will force women to incur risk of harms which they otherwise

would not incur because their health is at the bottom of a statutorily-mandated list of priorities. In practice, § 3210(b) will engage the state in further endangering women who already are in life- or health-threatening situations.

Because only abortions which are needed for life or health reasons are at issue in § 3210(b), affirmance of the Court of Appeals' invalidation of that section requires only that this Court reaffirm the principle that preservation of the woman's life or health outweighs any other interest related to abortion.

C. Section 3210(b) Creates Unconstitutionally Vague Standards For Measurement Of Risk And Fetal Care Which Will Chill Doctors From Providing Safe Abortions.

In addition to undercutting woman's health, § 3210(b) also fails to give physicians adequate notice of when selection of a certain abortion method will be deemed criminal.

The term "significantly greater" gives no guidance to the physician as to how much riskier a given abortion technique must be for the woman before he or she can reject that technique in favor of one safer for her but which lessens the chances of fetal viability. The physician must discount a certain amount of risk to the woman if it falls below the level of "significant," but exactly what quantum of risk that is cannot be discerned. The provision is thus unconstitutionally vague. *Colautti*, 439 U.S. at 400.

Appellants defend § 3210(b) by arguing, with no support, that the physician performing a post-viability abortion invariably will be able to quantify the risks associated with the possible methods as either obviously significant in their differences or obviously marginal. Def. B. at 87-88. This argument is premised on an assumed ability to quantify increments of risk which amounts to science fiction.

In fact, there is no way to measure on any objective scale the degree of risk posed by various post-viability techniques needed by women with different serious health problems. Not only is the data concerning relative risks scarce, but each determination is *sui generis*, depending upon a multiplicity of individualized factors. No doctor performing these kinds of

post-viability abortions could be secure in the knowledge that his or her measurement of risk would satisfy the statute.

Section 3210(b) forces the attending physician to consider every method of abortion in order of its likelihood to produce a live birth. The techniques that can be used for abortions after 24 weeks are the intra-amniotic instillation of solutions containing saline, prostaglandin, urea, or some combination of those substances, prostaglandin E_2 suppository, oxytocin or dilatation and evacuation (D&E).[8] There are no data comparing the live birth rates from use of these techniques after 24 weeks.[9] D&E allows no possibility of a living fetus.

Each woman receiving an abortion covered by § 3210(b) presents at the outset some kind of health problem, for which she already may be receiving treatment or medication. This condition or its treatment may create a unique configuration of risks and it may also already have adversely affected the fetus. To the considerations resulting from her particular diagnosis must be added the risks known to be associated with each method. For prostaglandin instillations, for example, contraindications include hypertension, asthma, glaucoma and epi-

---

8 Chervenak, Farley, Walters, Hobbins & Mahoney, *When is Termination of Pregnancy During the Third Trimester Morally Justifiable?* 310 N. Eng. J. Med. 501 (1984); Hern, *Serial Multiple Laminaria and Adjunctive Urea in Late Outpatient Dilatation and Evacuation Abortion*, 63 Obstet. & Gynecol. 543 (1984) ("Hern, Serial Multiple Laminaria"); *Williams Obstetrics* at 543. Because of the magnified danger they pose of death and major complication, hysterotomy and hysterectomy are no longer considered acceptable methods for abortion in the absence of additional health reasons for their use, such as cervical cancer. Diggory, *Hysterotomy and Hysterectomy* in Abortion and Sterilization: Medical and Social Aspects (J. Hodgson, ed. 1981) at 331; *Gynecology & Obstetrics* at 1222-3. One complicating factor in assessing the risks of various techniques is that some doctors are beginning to blend the possible techniques. For example, one physician uses laminaria for dilation, injects urea and then removes the fetal material by surgical evacuation. W. Hern, *Abortion Practice* 122-3 (1984).

9 *See* Robins & Surrago, *Alternatives in Midtrimester Abortion Induction*, 56 Obstet. & Gynecol. 716, 720 (1980) for a comparison of "live births" (but not viable births) subsequent to saline and prostaglandin abortions at 24 weeks or less. During the late second trimester, only prostaglandin is reported to result in live birth rates greater than a fraction of a percent.

lepsy.[10] Gastro-intestinal side effects, sometimes severe and prolonged, are common for prostaglandin abortions; almost 50 percent of the patients experience nausea, vomiting, and/or diarrhea.[11] Hypertension is also a contraindication for saline injections, as is sickle cell disease, anemia, heart disease, kidney disease, and blood coagulopathy.[12] The most frequent complications are hemorrage and infection. A disadvantage of both prostaglandin and saline procedures is the length of time patients are incapacitated.[13] Actual labor, which carries its own set of risks, may last four to 12 hours.[14]

The literature contains no contraindications based on the patient's health condition for the use of D&E.[15] In assessing the advisability of using D&E, the primary factor is the

10 Hern, *Abortion Practice* at 125.

11 Kerenyi, *Intraamniotic Techniques* in Abortion and Sterilization at 368. Additionally, chills, fever, coughing, and shortness of breath, as well as more severe respiratory and cardiovascular complications, have been observed in patients receiving prostaglandins. *Id.* After a prostaglandin procedure is completed, a dilatation and curettage may be "routinely" required "since emptying of the uterus is so frequently incomplete." K.R. Niswander, *Manual of Obstetrics* (1980) at 22.

12 Kerenyi, *Hypertoxic Saline Instillation* in G.S. Berger, et al., Second Trimester Abortions: Perspectives After a Decade's Experience 179 (1981); Niswander, at 22. Hypernatremia (excessive increase in serum/sodium levels) occurs less often, but with results ranging from headaches and dizziness to seizures and coma. Kerenyi, *Intraamniotic Techniques* at 363.

13 The overall injection to abortion interval is approximately 24 hours for saline (somewhat shorter if combined with oxytocin), and 16 hours for prostaglandin. Binkin, Schulz, Grimes & Cates, *Urea-Prostaglandin Versus Hypertonic Saline For Instillation Abortion*, 146 Am. J. Obstet. Gynecol. 947, 949 (1983).

14 Rooks & Cates, *Emotional Impact of D&E vs. Instillation*, 9 Fam. Plan. Persp. 276 (1977).

15 As a surgical procedure, however, it always carries the risk of cervical laceration and even perforation. Other complications include excessive blood loss, hemorrhage and pelvic infection. Peterson, et al., *Second Trimester Abortion by Dilatation and Evacuation: An Analysis of 11,747 Cases*, 62 Obset. & Gynecol. 185 (1983).

individual physician's level of skill and training.[16] During the second trimester of pregnancy, D&E is now recognized as the safest method of abortion. *City of Akron*, 462 U.S. at 436. Although it was once thought to be safe only early in the second trimester, now physicians skilled in the technique can successfully use it as the method of choice for both late second-trimester and third-trimester abortions.[17]

Conscientious physicians who must comply with § 3210(b) will face impossible questions in trying to select a method which will both insulate them from prosecution and protect the health of their patients. For a physician who is skilled in D&E, for example, that procedure might very well be considered the safest, most comfortable, and least traumatic one for the patient. But any such doctor would be in a quandary as to how much less the risk to the woman must be before the D&E would not be criminal. What if a hypertensive patient has contraindications for both kinds of instillation? Are recognized contraindications enough, or must the risk of mortality reach a certain threshold? If so, what is that threshold? How severe must the hypertension or asthma or epilepsy be before the physician rules out the use of prostaglandin? What level of anemia or kidney disease constitutes a "significantly greater" risk for saline? Does the statute intend to compel the forcing of human beings to spend up to 12 hours in labor and more hours vomiting and with diarrhea? To these questions must be added the considerations unique to each patient's case.

The physician's dilemma is compounded by the fact that, because so few abortions after 24 weeks are performed, comparative morbidity data which segregate that time period are virtually non-existent. So he or she is left with no reference point to assist in the assessment of risk and no defense if a

16 Cates & Grimes, *Morbidity and Mortality of Abortion in the United States* in Abortion and Sterilization at 156-58.

17 Hern, *Serial Multiple Laminaria.* Letter from Dr. Warren Hern to Janet Benshoof (June 28, 1985) (see Appendix A to this brief at 1a-4a), provides examples of three safe late D&E procedures, combined with laminaria. One was performed at 30 weeks, the other two at 27 weeks.

local prosecutor later wants to second-quess whether a given risk was "significantly greater."

In addition to the method choice provision, Section 3210(b) also requires the physician performing a post-viability abortion to use the same overall standard of care toward the fetus that would be used if the fetus were intended to be born rather than aborted. This clause contains no exception for the woman's life or health, and thus is even more clouded in its ramifications for when treatment choices to insure the woman's well-being might result in criminal prosecution.[18] Furthermore, the standard of care provision is ambiguous on whether it imposes a subjective or objective standard for determining liability.

As the Third Circuit realized, these problems become all the more serious in the intrusions they generate on the exercise of a fundamental right because they often will occur at the borderline of viability. *American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283, 299-300 (3rd Cir. 1984). The uncertainty of determining viability, coupled with a margin of error of about 11 days,[19] will force physicians to hedge their bets in ways detrimental to women's health even for abortions before viability.[20]

---

18 For example, any fetus manifesting signs of life or movement after a post-viability procedure will be extremely premature. Premature infants often suffer from Repiratory Distress Syndrome (RDS). *See Williams Obstetrics* at 769; Schmidt, Sims, Strassner, Paul, Mueller, McCart, *Effect of Antepartum Glucocorticoid Administration Upon Neonatal Respiratory Distress Syndrome and Prenatal Infection*, 148 Am. J. Obstet. & Gynecol. 178 (1984). Steroids are administered to the pregnant woman who threatens to deliver prematurely because steriods enhance fetal lung capacity and increase the chances of viability. *See Williams Obstetrics* at 755; Schmidt et al., at 178. Steroids, however, are contraindicated for pregnant women with hypertension or diabetes. 29 *Physician's Desk Reference*, 1764 (1984). Because the degree of care provision requires the doctor to do whatever is necessary to ensure fetal viability, he or she would be unsure under this section whether it was required to administer the steroids, a treatment for the fetus that could endanger the woman.

19 *See Colautti*, 439 U.S. at 395 and Grimes at 264.

20 The reach of this health-subverting provision does not end there. As Pennsylvania defines abortions, its scope will include any premature pregnancy termination which carries "a reasonable likelihood" of causing fetal death. See *supra*, n. 3. This will include any premature delivery procedure when the fetus is seriously at risk. The impact of § 3210(b) in these situations will be to distort appropriate medical judgments to compel use of the "best" method for the fetus (even if *all* the methods under consideration provide a chance of fetal survival) by forcing the woman to assume some greater degree of health or life endangerment.

D. Section 3210(b) Will Deprive Women Needing Abortions of The Medical Advice and Care On Which They Can Rely To Protect Their Health.

In making the decision whether to have an abortion, a woman is entitled to receive the best medical advice which her physician can provide. For that reason, the physician must be accorded " 'the room he needs to make his best medical judgment.' " *City of Akron*, 416 U.S. at 427 quoting *Doe v. Bolton*, 410 U.S. 179, 192 (1973). "The physician's exercise of this medical judgment encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion." *City of Akron*, 416 U.S. at 427 (citations omitted).

In no situation is the woman's need for medical advice based solely on her own health interests more compelling than prior to an abortion necessary to preserve her life or health. The later the pregnancy and the more dangerous the abortion, the stronger her privacy-grounded right to the protection of her own life and health.

Section 3210(b) violates the abortion right for these women by forcing the woman's doctor to render medical care and advice which weighs her health against the fetus' in the shadow of a threatened criminal prosecution. In many situations, it will preclude consideration of methods which are safest for the woman, and it inescapably skews the medical judgment upon which women are entitled to rely.[21] Furthermore, women may

---

21 Indeed, the rationale for allowing the state to require a second physician to attend a post-viability abortion is that the woman's doctor will be acting to carry out her best interests, which might be contrary to those of the fetus. *Ashcroft*, 462 U.S. at 476. Section 3210(b) turns this principle on its head, by depriving women of access to a physician upon whom they can rely for advice and care solely in their interests.

not even be aware that the medical advice they receive is based on any consideration other than the protection of their life and health.

E. A Woman's Right To Obtain An Abortion Needed For Her Life Or Health Includes A Right To Decide Which Risks She Is Prepared To Accept.

The right to choose an abortion includes the right to effectuate that decision. *Akron*, 462 U.S. at 430. Although the state may entirely prohibit purely elective abortions after viability, those women who need abortions for life or health reasons at that stage of pregnancy retain the right to terminate their pregnancies. *Roe*, 410 U.S. at 163-4. The State's attempt, through § 3210(b), to deprive women of the choice of the method to be used, would eviscerate the decisional right itself.

A woman affected by § 3210(b) is one whose life or health necessitates an abortion performed late in the pregnancy when it is most dangerous. For her, more than for most abortion patients,

> "[t]he decision to have an abortion has 'implications far broader than those associated with most other kinds of medical treatment' and thus . . . it [should be] made 'in light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient.' " *City of Akron*, 462 U.S. at 443 (citation omitted).[22]

22 This Court has also ruled that abortion must be treated by the states in a manner consistent with the regulation of other medical procedures. States may not adopt "abortion regulations that depart from accepted medical practice." *Akron*, 462 U.S. at 431. As with other surgical procedures, the final weighing and assuming of risks of an abortion necessary for life or health must be left to the patient. After she has been fully advised of the range and nature of the possible complications associated with the various methods, the patient "is the one to decide which of the possible consequences [s]he wants to risk." *Dunham v. Wright*, 423 F. 2d 940, 945 (3d Cir. 1970) (applying Pennsylvania law). "The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone." *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972).

She, especially, is entitled to weigh and resolve the ramifications of selecting one method rather than another—the likelihood one might entail of undergoing prolonged labor versus the possibility inherent in another of serious perforation, or the risk of bringing to birth and short, painful life a seriously impaired infant.[23]

The possibility that the fetus will emerge manifesting signs of life for moments before its death creates a serious, not trivial, threat to the emotional well-being of a woman whose own life or health requires the abortion.[24] A woman carrying a fetus which has an abnormality prohibitive of normal life expectancy could nonetheless be forced under § 3210(b) to undergo labor and delivery in order to maximize the chances for the fetus to be aborted alive. A woman who lawfully has decided, perhaps with great anguish, not to bring into being a fatally impaired child cannot be compelled to witness the death of that child by any principle of law consistent with due process.

Considerations of this magnitude will determine not just the preference for a particular method but the underlying decision itself. Section 3210(b) would prohibit the woman from exercising her own best judgment, in the context of a medical procedure needed for her life or health, about which conse-

23 A child born with Tay-Sachs disease, for example, with a life expectancy of four years, was found to suffer from

> mental retardation, susceptibility to other diseases, convulsions, sluggishness, apathy, failure to fix objects with her eyes, inability to take an interest in her surroundings, loss of motor reactions, inability to sit up or hold her head up, loss of weight, muscle atrophy, blindness, pseudobulper palsy, inability to feed orally, decerebrate rigidity and gross physical deformity. *Curlender v. Bio-Science Laboratories*, 106 Cal. App. 3d 811, 816, 165 Cal. Rptr. 477, 480-481 (1980).

24 In a clinical study to compare D&E with prostaglandin instillation for second trimester abortions, three of the women who had been randomly assigned to the prostaglandin group dropped out of the study because of their fear of a long, painful labor culminated by abortion in bed. Grimes, Hulka, & McCutchen, *Midtrimester Abortion by Dilatation and Evacuation Versus Intra-Amniotic Instillation of Prostaglandin $F_{2\alpha}$: A Randomized Clinical Trial*, 137 Am. J. Obstet. Gynecol. 785, 789 (1980).

quences she could best endure. Such a barrier is forbidden by the principles reaffirmed in *City of Akron*, which held that even the state's compelling interest in the woman's health "will not justify abortion regulations designed to influence the woman's informed choice between abortion or childbirth." 462 U.S. at 444.

II. THE REQUIREMENTS OF SECTIONS 3205 AND 3208 ARE DESIGNED TO CONVINCE WOMEN NOT TO HAVE ABOFTIONS, TO INTERFERE WITH THE INFORMED CONSENT PROCESS, AND TO FORCE DOCTORS TO PRESENT INFORMATION THAT MAY BE INAPPROPRIATE, HARMFUL OR BIASED.

Sections 3205 and 3208 purport to ensure an "informed consent" for the abortion decision. In reality, this section subverts the general purposes of informed consent and serves to conceal choices which have been taken out of the woman's hands by other sections of the statute.

A. Section 3205(a)(1)(iii) Encourages Doctors To Ignore The Informed Consent Process For Women Needing Post-Viability Abortions.

Section 3210(b) requires that the doctor performing a post-viability abortion weigh the risks to the mother and the risks to the fetus, and then unilaterally decide which abortion technique to use. Section 3205(a)(1)(iii) requires a doctor only to tell a woman "the particular medical risks associated with *the particular abortion procedure to be employed*." (emphasis added) This informed consent section, therefore, permits doctors to conceal the entire weighing process they have undertaken as mandated by § 3210(b). Women in need of life or health-saving post-viability abortions are never informed of the availability or risks of alternative abortion procedures. The woman may never be told that the fetus has been balanced against her health in the choice of the particular technique or that other doctors may weigh risks differently.[25] She may never

25 Although a doctor arguably could add information to explain this, the protection against civil liability if § 3205 is followed [see § 3205(d)] would discourage doctors from deviating from this section.

be given the information which would give her the opportunity to decide if this is the best doctor or choice for her.[26]

B. The Informed Consent Requirements Of The Statute Depend Upon The Interplay Of Sections 3205 And 3208.

The state attempts to disguise the full impact of the informed consent requirements by separating sections 3205 and 3208. (Def.B., p. 65.) Yet the statute plainly states that there is no informed consent unless the physician or an agent not only informs the patient of the availability of the material described in § 3208, but also informs her that the materials describe the unborn child and offer alternatives, and also answers questions about the material itself. § 3205(a)(iii).

It is understandable that the State has chosen to downplay the relationship of the § 3208 material to § 3205 in light of its admission that merely offering this § 3208 information to women could be detrimental to their health. (Stipulation 109, J.A. p. 45a.)

The state further claims that the § 3208 material is not objectionable because its presentation is optional. This ignores the fact that many women will believe that the doctor encourages and endorses the material, thereby making it not truly "optional".[27] Women who are likely to be "traumatized" by

26 In contrast, the Pennsylvania Legislature has comprehensively defined informed consent as it applies to all procedures *except* abortion. The "Hutchinson Amendment" to the Health Care Services Malpractice Act, 40 Pa. Stat. Ann. § 1301.101 et seq. (Purdon 1982-83 Supp.) was enacted specifically to ensure "the patient's right to know the type of treatment that he is to receive, the risks, the alternatives that are available to him with respect to treatment as opposed to the problems that the medical profession faces in connection with the therapeutic process." Comments of Rep. Hutchinson, 66 Pa. Legis. J. House, 2318-2319 (July 21, 1975). Thus the law requires that all patients are informed of "those risks, possible consequences, and alternatives to treatment that a reasonable patient would consider material to his decision whether or not to undergo treatment." 40 Pa. Stat. Ann. § 1301.103

27 It is unrealistic to assume that a woman in such a stressful situation will readily distinguish between information she has a "right to review," information the doctor "orally" describes to her upon her request or upon

such disclosure will suffer harmful effects whether the materials presented are mandatory or not. (Stipulation 98, 109, J.A. pp. 41a, 45a) Only the doctor or trained counselors, in conjunction with the woman, can know exactly which information will contribute to a particular woman's informed consent.

C. The Statute's Rote Recitation Requirements Undermine True Informed Consent for Many Women.

The informed consent provisions of the Abortion Control Act, §§ 3205 and 3208, are not merely a departure from the Pennsylvania informed consent law which governs all other medical practices.[28] Sections 3205 and 3208, include several statements designed to convey to the woman that abortion is not the best decision.[29] The state suggests that any detrimental

---

the doctor's own judgment, and information which the state requires. The § 3208 material is the only material singled out for special mention, and the patient will not know if it is "optional" because the state made it so or because the doctor is holding back necessary information.

28 *Compare* Sections 3205 and 3208, requiring that the doctor or his agent recite eight categories of information to each and every abortion patient with the Pennsylvania "Health Care Services Malpractice Act," 40 Pa. Stat. Ann. § 1301.101 et seq., which gives physicians great leeway to provide the patient with information that "a reasonable patient would consider material to the decision," and allows the doctor to omit any information that "would have resulted in a seriously adverse effect on the patient or on the therapeutic process . . ." 40 Pa. Stat. Ann. § 1301.103

29 For exampl[illegible] 3205(a)(1)(iii) requires that the woman be informed "that there may be [illegible]imental physical and psychological effects which are not accurately forse[illegible]" § 3205(a)(2)(ii) requires that the woman be informed "that the fath[illegible]ble to assist in the support of her child, even in instances where the fath[illegible]offered to pay for the abortion;" and § 3205(a)(2)(iii) requires that [illegible]an be informed that she has "the right to review the printed materia[illegible]described in § 3208." Section 3208(a)(2) requires that printed materials d[illegible]ibe "the probable anatomical and physiological characteristics of the unbo[illegible] child at two week gestational increments from fertilization to full term". In addition, § 3208(a)(1) includes a statement that "[t]he Commonwealth of Pennsylvania strongly urges you to contact [childbirth and adoption agencies] before making a final decision about abortion."

affects can be mitigated suggesting physicians or counselors "*should* give *additional information* which tailors the explanation to each woman's personal circumstances." (Def.B., pp. 69-70, n. 24) (emphasis added)

A patient's confidence and trust in her doctor or counselor, is an underlying component of informed consent. It is difficult to conceive this trust being built when the woman must differentiate between the doctor's advice to her, state-required pronouncements, and "additional information" intended to supplement or disclaim the government information.

Doctors are required to orally inform the woman that she has the right to review materials which describe the "unborn child." The State does not attempt to suggest what "additional information" (Def.B., pp. 69-70, n.24) could mitigate the effects of this on women who are choosing abortion because the fetus is severely deformed or because their life is in danger. The state blithely assumes that graphic descriptions of "the unborn child" through all stages of pregnancy are relevant to all women, regardless of their individual circumstances. The state also assumes that for a pregnant woman, informed consent involves only a choice between full-term childbirth or immediate abortion. (Def.Br., pp. 70-71.) This is not always true. For some women needing medical treatment of diseases such as cancer, abortion is one of several options in an informed consent discussion. If for example, a woman who is 24 weeks pregnant presents with metastatic breast cancer, she will require chemotherapy to arrest the cancer. Such chemotherapy endangers the fetus. The options, therefore, include: (1) delaying maternal treatment until full term delivery—an unacceptable maternal risk for most women; (2) performing immediate abortion and providing immediate treatment to the woman; or (3) (an in-b[illegible]ween choice) delaying 4-6 weeks and delivering the fetus by cesarean section after maternal treatment with steroids, in an effort to improve fetal survival. The pregnant woman and her family, depending upon their desire for an infant and willingness to accept the various risks, should

be informed of these options and be permitted to decide on the treatment to be given.[30]

There are other ways in which this statute precludes doctors from exercising their best medical judgment. Section 3205(a)(iii) requires doctors to warn all women of "unforeseeable" medical risks of abortion, despite the fact that abortion, particularly early abortion, has been the most studied medical procedure in the United States. After 15 million abortions, some risks may be remote but none are "unforseeable."[31]

Even if a woman has already made her decision to abort, either on her own, in consultation with her personal doctor, family, clergy, or friends, the doctor is required to make available information which *urges* her to further delay her abortion decision until she has contacted childbirth and adoption agencies. Patients will be confused and possibly harmed by a message from the state which urges them to delay the

30 Stubblefield, "Some Medical Considerations," in Rhoden, Stubblefield, Benshoof & Callahan, *Late Abortion and Technological Advances in Fetal Viability*, 17 Fam. Plan. Persp. 160, 162 (1984). Similar options apply in the choice of treatment for cervical carcinoma. See, Lee, Neglia & Park, *Cervical Carcinoma in Pregnancy*, 58 Obstet. & Gynecol. 584, 586-587 (1981). The effects of certain drugs on the fetus constitute a major consideration in pregnancy-associated therapeutics. Barber, *Fetal and Neonatal Effects of Cytotoxic Agents*, 58 Obstet. & Gynecol. 415, 425 (1981).

31 Consent does not become "informed" as a result of outdated or inaccurate information. While once it may have been desirable and accurate for Pennsylvania to require a warning about "unforseeable risks" due to abortion, *Planned Parenthood Association v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975), *aff'd mem. sub. nom. Franklin v. Fitzpatrick*, 428 U.S. 901 (1976), this is no longer the case. "A clandestine procedure before '970, abortion has been thrust into the medical arena—where procedures can be performed more safely, techniques improved, and costs reduced. We now know more about induced abortion than any other surgical procedure." Cates, *Legal Abortions and Women's Health Gains and Losses in the 1970's* reprinted as *Legal Abortion: The Public Health Record*, 215 Science 1586 (1982). How can a doctor answer a woman's questions about what these supposed risks are if he or she doesn't know of any that are "unforseeable"?

abortion when any competent doctor will give the opposite advice.[32]

The nonmedical pronouncements required by § 3205 (a)(2)(i-ii) are likely to raise questions for the woman which medical personnel are ill suited to answer and which may give some women false expectations.[33]

D. The Prepared Speech Requirements Of Sections 3205 And 3208 Are Unconstitutional Under The Standard Set Forth In *Akron*.

The Third Circuit was correct in holding the informed consent requirements imposed by 3205 and 3208 to be squarely governed by this Court's decision in *Akron*, 462 U.S. 416 (1983).

Akron reaffirmed that physicians must be given room to make medical judgments, not only in the provision of abortion services but also in "assisting the woman in the decisionmaking process." 462 U.S. at 427. Although certain state regulations may be enacted that impose on the first trimester of pregnancy; such as the reporting and informed consent requirements upheld in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); such regulations are constitutional in the first trimester only if there is no significant impact on the woman's exercise of the abortion right and such regulations are justified by "important state health objectives." *Akron*, 462 U.S. at 430. The blanket imposition of §§ 3205 and 3208 violates both these standards. The information is designed to skew a choice to childbirth, and to interfere with the physi-

32 Delaying abortion adds directly to the risks of complication and death. Cates & Grimes, *Morbidity and Mortality of Abortion in the United States*, in Abortion and Sterility at 158; Centers for Disease Control, Dept. of Health and Human Services, *Abortion Surveillance 1979-1980 (1983)* at 10.

33 National statistics show that as of 1982, 41% of women living with a child under 21 years of age whose father was not in the household were not awarded child support, and that less than 50% of the women awarded child support received the full amount. *U.S. Dep't of Commerce, Bureau of the Census, Current Population Reports, Special Studies*, Series P-23, No. 124 (1982).

cian's best medical judgment; both factors having a significant impact on the woman. There is no health justification for these requirements and the state has admitted they may be detrimental to health. These sections, therefore, constitute an unconstitutional interference with a woman's privacy right. *Akron* 462 U.S. at 427-431.

E. The Statute Requires The Physician To Be The Agent For The State's Campaign To Influence A Woman Against Abortion In Violation Of The First Amendment.

In the definition section of the statute, 3203, the legislature defines "unborn child" as "a human being from fertilization until birth . . . ." The expressed legislative policy of trying to stop abortion is implemented by forcing doctors to make pronouncements designed to cast doubt on an abortion decision and to encourage childbirth.[34] The physician is compelled to make certain pronouncements for the state with which he or she might profoundly disagree. As this Court has observed, "where the State's interest is to disseminate an ideology, no matter how acceptable to some, such interest cannot outweigh an individual's First Amendment right to avoid becoming the courier for such message." *Wooley v. Maynard*, 430 U.S. 705, 717 (1977). *See also, West Virginia Board of Education v. Barnette*, 319 U.S. 624, 642 (1943).

The dictated counseling requirements would replace the neutral information now provided, and place "pro-childbirth" speech in a preferred position. Content-based regulation of speech requires the strictest scrutiny. *See Carey v. Brown*, 447 U.S. 455, 461-62 (1980). The impermissibility of this particular forced speech is underscored by this Court's admonition that the state cannot adopt one "theory of life" that overrides a woman's privacy right. *Roe v. Wade*, 410 U.S. at 162.[35]

---

34 See brief for the United States as *Amicus Curiae* in Support of Appellants at 18.

35 The First Amendment also protects a right to listen and receive information, *see Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 756-57 (1976), and it is undisputed that this includes information about abortion. *Bigelow v. Virginia*, 421 U.S. 809, 821-22 (1975). The woman listening to the required litany is in every sense a captive audience. If she does not go through the required counseling, she will be unable to obtain an abortion. Because she has no choice but to listen, her right not to receive information must be especially protected. *See Kovacs v. Cooper*, 336 U.S. 77, 86-87 (1949); *Public Utilities Commission v. Pollak*, 343 U.S. 451, 468 (1952), (Douglas, J., dissenting).

III THE REPORTING REQUIREMENTS OF SECTION 3214 HAVE A SIGNIFICANT IMPACT ON A WOMAN'S ABORTION DECISION WITHOUT FURTHERING ANY HEALTH INTERESTS.

The Pennsylvania Abortion Control Act contains two sections regarding reporting requirements [§§ 3207(b) and 3214(a)-(i)]. Three subparts § 3214(a), (b) and (h) are before this Court. On June 17, 1985 the district court in this case held a hearing and enjoined §§ 3207(b) and 3214(f) requiring public disclosure of the required reports on facilities because they violated privacy rights. That court made numerous findings of fact which are applicable to the subsections of the reporting section that are before this Court.[36]

A. The New Reporting Requirements Do Not Further Any Maternal Health Interests.

Abortion providers in Pennsylvania have been reporting composite data on abortions to the State Health Department since 1974.[37] In turn, the state has routinely submitted the data to the federal government's Centers for Disease Control for its national abortion surveillance work. The new reporting forms prescribe a separate form and detailed information on each abortion.[38] Moreover, the new reporting statute requires each individual abortion form, as well as separate facility or doctors' reports, to be disclosed to the public.

---

36 See Findings of Fact, Discussion, Conclusions of Law, and Order, No. 82-4336 (E.D. Pa. June 17, 1985), (hereafter "Findings of Fact"), a copy of which is appended to plaintiffs' brief.

37 See "Quarterly Report of Abortions Performed," App. B to this brief at 4a-7a.

38 See Def. B., p. 55a and § 3214(a).

The appeliants have never justified the many details required by the reporting section of the Act. Instead, they simply assert that the information required "in many respects" (Def. B. p. 61) corresponds to national abortion data collected by the Centers for Disease Control (CDC). However, Pennsylvania, under its present reporting system, has supplied CDC with all the data necessary for the abortion surveillance reports.[39] Appellants have not given any reason to this Court why public disclosure of each individual report furthers health interests, although they admitted in the district court that the state interest in the public disclosure sections was not to further health but to "facilitate the First Amendment rights of those opposed to abortion." Findings of Fact, Slip Op. at 37.

The inadequacy of any maternal health interests is further evidenced by a comparison to the reporting statutes of the twenty-six other states that have such requirements.[40] No other state requires public disclosure of the reports,[41] while twenty-three states explicitly require confidentiality of the reports.[42]

---

39 The specific data reported by CDC for each state includes: 1) residence status (state versus out of state); 2) age; 3) race; 4) marital status; 5) number of live births; 6) type of procedure; 7) weeks of gestation; 8) previous induced abortions; 9) weeks of gestation and procedure; 10) weeks of gestation and age group; 11) weeks of gestation and race; 12) age group and race; 13) marital status by race; and 14) death-to-case rate for legal abortions by type of procedure, and by weeks of gestation. Preface to Centers for Disease Control, U.S. Dept. of Health and Human Services, *Abortion Surveillance: Annual Summary 1979-1980* (1983).

40 *See* List of State Statutes App. C to this brief at 13a.

41 Idaho allows public access to statistical compilations only, based on the reports. Idaho Code § 39-261(b) (Supp. 1984). Missouri only allows the statistical data to be inspected and acquired by local state or national public health officers. Mo. Rev. Stat. § 188.055(2) (Supp. 1982). While these states allow limited access to the statistical data based on the reports, only Pennsylvania permits the general public to have access to the actual report forms.

42 *See* List of State Statutes on confidentiality, App. D to this brief at 14a.

B. The Reporting Requirements Of Section 3214 Expose Women Receiving Abortions To Harassment Because They Permit Disclosure Of Individual Identities.

Individual women visiting abortion providers or women who have sought and received abortions have increasingly become targets of anti-abortion harassment.[43] Public disclosure of a woman's identity is one form of harrassment.[44] The specificity of the report forms required by § 3214(a)(2)-(14) permit identification of some of the women by anyone. The statute requires that the political subdivision in which the woman resides be reported, (§ 3214(a)(2)); as well as her age, race and marital status (§ 3214(a)(6)). In Pennsylvania, political subdivision can include county, town, city, ward, census track, or precinct. Thus, a political subdivision within the meaning of § 3214 could include an area as large as a thirty mile county (Sullivan) or as small as a city ward. That fact, combined with details such as race, age, and marital status could be used to easily identify a woman who had had an abortion and who lived, for example, in a sparsely populated area.[45]

---

43 See Findings of Fact and Donovan, *The Holy War*, 17 Fam. Plan. Persp. 5 (1985).

44 In a recently published book, J. M. Scheidler, *Closed: 99 Ways To Stop Abortion* (Ignatius Press, San Francisco, Cal. 1985), the author, who is the director of the Pro-Life Action League, goes so far as to recomend the use of private detectives. The repercussions of being identified can be devastating. One young woman was thrown out of her home and forced to drop out of college after an anonymous caller told her parents that she had been to the Women's Health Center in Duluth, Minnesota, a facility which performs abortions. See "Letter from Katherine R. Welsh to Janet Benshoof (August 2, 1985), App. E to this brief. A lawsuit was brought by another young woman against an anti-abortion organization and the hospital where she obtained an abortion after anti-abortion activists informed her parents by telephone and mail about her recent abortion. The woman's close relationship with her mother was ruined because of these communications. Japanga, "Abortion Suit Brought on by Privacy Issue", *The Los Angeles Times*, April 10, 1984 at p. 2.

45 In 1980, there were only six black women of childbearing age living in Sullivan County. General Population Characteristics, 1980 Bureau of Census, Pennsylvania, p. 66. Of these women, one was 17 years old, two were 18, one was nineteen, two were twenty. Thus, the one nineteen-year-old

For women who have had late abortions because of medical problems or fetal anomalies the loss of anonymity is particularly traumatic because of the additional information the forms disclose.[46]

C. The Reporting Requirements Of Section 3214 Permit Identification Of Doctors Which Will Result In Harassment And Chill Doctors.

A facility, as defined in the § 3203, includes a physician's office. The proposed reporting forms require the name and county of the facility where the reported abortion is performed,[47] and section 3214(h)(4), relating to abortion complications, requires the name and address of the facility where the abortion is performed.[48] Any doctor who performs abortions in his or her office can easily be traced through the information supplied on these report forms. This is true despite the fact 3214(e)(2) allows the physician's name to be substituted by an identifying number.

Many doctors, particularly in nonmetropolitan areas, faced with the prospect of public disclosure of reports by which they

---

black woman residing in Sullivan County who had an abortion is easily identified by anyone examining the required report form. A woman living in a large city such as Pittsburgh could also be identified. For example, in census tract number 2503 of Pittsburgh, there were only ten white females aged 20-24. Table P-2, General Characteristics of White Persons: 1980 Census of Population In Housing User's Guide, Pittsburgh, PA.

46 Section 3211(a) for example requires that the physician indicate the basis for the medical judgment that abortion is mandated. A woman who undergoes a late trimester abortion because the fetus has severe congenital defects, for example, not only loses her anonymity but has no protection from other intimate details being made available to the general public.

47 Section 3214(a)(1). See also Def. B., p. 55(a) for copies of the proposed forms.

48 See Def. B., pp. 56(a)-57(a). Additionally, Section 3207(b), enjoined by the district court on June 17, 1985, requires additional data on any facility where an abortion is performed. See Findings of Fact.

may be identified as referring for or performing abortion procedure, will stop providing this services to women.[49]

For many women in this country, abortion is not readily accessible.[50] In the last three years, incidents of harassment and intimidation against doctors and clinic staff who provide abortion counselling and procedures have risen in number and intensity.[51] These incidents of harassment have taken place at clinics, hospitals, and at the homes of doctors and clinic staff.[52] The fear of such incidents will have a chilling effect on

---

49 See Findings of Fact Nos. 3 and 24. Tracing the identity of a doctor is facilitated by public access to a great deal of information. For example, a physician in Mercer County would have to list the name of his or her office where the abortion was performed, the referring doctor (§ 3214(a)(1)) and/or the name and address of any parent, subsidiary, or affiliated organization, corporations, or associations (§ 3207(b)) (currently under a preliminary injunction, Findings of Fact). Public access to such information negates the "protection" offered by the statute by its requiring a number in lieu of the physician's name. The loss of doctors in nonmetropolitan areas who are identified and harassed to the point of ceasing to provide abortion services will greatly burden accessibility to abortion services for many women who would then have to travel to a city to obtain an abortion. Those that cannot do that will be precluded from access to abortions. Henshaw, Forrest & Blaine, *Abortion Services in the United States, 1981 and 1982*, 16 Fam. Plan. Persp. 119, 123 (1984).

50 As of 1982, 78 percent of all United States counties have no identified abortion service providers, while 28 percent of all women of reproductive age live in such counties. Henshaw, Forrest & Blaine at 123.

51 For example, between 1977-1980, there were four reported bombings and no bomb threats, 35 invasions, one death threat, and five reported incidents of assaults/batteries. In the period between 1982 and 1985 (as of July 3rd) these activities had steadily increased. There were a total of 27 reported bombings; 111 bomb threats to clinics; 86 invasions; 13 death threats; and 18 reported incidents of assaults/batteries. Between 1977-1980 the total number of specific incidents of clinic violence (as reported to the National Abortion Federation) was 61; between 1981-1985, the total number of such incidents was 411. *Summary of Clinic Violence as Reported to the National Abortion Federation*, a copy of which is being lodged with the Clerk of the Court by *Amicus Curiae* National Abortion Federation. See also Findings of Fact, Nos. 9, 13, 18, 23, 29, 33, 35, 40, 41, 46, 50, 58, 60 and 68 and Stip. J.A. No. 192, pp. 50a-51a.

52 *Id.* Hospitals have proven to be very susceptible to the pressure exerted by anti-abortion activists. Recent *Philadelphia Inquirer* articles have

the number of doctors willing to continue to provide abortion services. Prior to the 1982 Pennsylvania Abortion Control Act, the Department separated the abortion records submitted by facilities from the cover sheet which identified the facility.[53] The policy recognized that "certain facilities and physicians could be pressured and possibly harassed by members of the public objecting to the medical abortion practice and that such harassmen could be detrimetal to women's health".[54] Because appellants have stated that the purpose of public disclosure is to aid the First Amendment rights of anti-abortionists,[55] it is clear that identification of doctors and patients is a foreseen outcome of these reporting requirements.[56]

The facts clearly indicate that violations of the anonymity of women and doctors, as well as subsequent harassment is a

---

reported that two hospitals, Delaware County Memorial and Metropoiitan Hospital, Springfield Division, have decided to stop performing abortions. One article noted that Delaware County Hospital took such action after anti-abortionists picketed "with signs of names of hospital doctors printed beside the words 'Baby Killers'." Solovitch, "Hospital's abortion ban gratifies protestors", *Philadelphia Inquirer*, May 26, 1985 at pp. 1B, 8B; DiGirolamo, "2nd Hospital to Limit Abortions", *Philadelphia Inquirer*, July 4, 1985 at B9. Hospitals are important abortion providers (48 percent nationally of facilities where abortions are performed.) Henshaw, Forrest & Blaine, 1981-1982 at 123.

53 Findings of Fact, No. 4.

54 *Id.* The policy also noted that "patient care may suffer if physicians or abortion clinics are under harassment." Findings of Fact No. 4.

55 See Findings of Fact, slip op. at 20 and 37. Defendants' Brief in this Court omits any reference whatsoever to the district court hearing on the public disclosure issue, their arguments made therein, as well as that court's findings and order enjoining §§ 3207(b) and 3214(f) despite the fact the district court found: "Defendants devote[d] the lion's share of their initial memorandum [to the trial court on these sections] to arguing that disclosure . . . is justified by the state's compelling interest in facilitating the First Amendment rights of those opposed to abortion." *Id.* at 37.

56 § 3214(e)(4) makes it a misdemeanor of the third degree to disclose this type of reported information. The fact that the Commonwealth sought to take some steps (albeit inadequate ones) to protect doctors' identities by § 3214(e) must also be seen as an acknowledgement by defendants of the dangers inherent in such disclosure.

reality, and will serve to be an effective tactic in deterring doctors from continuing to perform abortions and women from obtaining them.[57]

D. The Reporting Requirements Of Section 3214 Are Unconstitutional.

The reporting requirements significantly burden a pregnant woman's abortion decision by threatening removal of anonymity—an essential component of her right to privacy.[58] *Planned Parenthood v. Danforth*, 428 U.S. at 76. Because they burden the abortion right and are unjustified by any compelling state interest they are unconstitutional.

The reporting statute exceeds the strictures imposed by this Court on recordkeeping requirements. *Planned Parenthood of Missouri v. Danforth*, 428 U.S. at 81. Reporting requirements must "properly respect a patient's confidentiality and privacy . . ." *Id.* at 80. In other instances where personal data is required to be reported to the state, the legitimacy of such requirements turns on whether there exist sufficient safeguards for the protection of the individual's privacy right.[59] No such

---

57 See Findings of Fact Nos. 3 and 24.

58 Thus pseudonyms are permitted in cases where women (adult and minor) have challenged abortion laws, as in *Roe v. Wade*, 410 U.S. 113, 120, fn.4 (1973); *Doe v. Bolton*, 410 U.S. 179, 186 (1973); *Beal v. Doe*, 432 U.S. 438 (1977); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); and *H.L. v. Matheson*, 450 U.S. 398 (1981).

59 For example, in *Whalen v. Roe*, 429 U.S. 589 (1977), where a New York statute required reporting to the state of those patients who were prescribed particular drugs this Court noted that such reporting statutes must "evidence a proper concern with, and protection of, the individual's interest in privacy." *Whalen* at 605. See also *Brown v. Socialist Workers '74 Camp. Comm.*, 459 U.S. 87 (1982) regarding campaign disclosure requirements, and their applicability to minor political parties. Those requirements were held to be inapplicable to plaintiffs because a showing was made of reasonable probability of threats, harassment and reprisals based on disclosure. *Brown* at 100. As the facts make clear here, (*supra* at 22-27), public disclosure of the abortion reports will inevitably lead to the identification of individual women and doctors and subject them to acts of harassment and intimidation, as well as possible violence.

safeguards exist under this Statute and it is therefore unconstitutional.

IV. THE SUPREME COURT'S DECISION IN *AKRON* SETTLED THE LAW AS TO THE CONSTITUTIONAL STANDARD GOVERNING STATE STATUTES REGULATING ABORTION.

This Court most recently reaffirmed the constitutional principles established in *Roe v. Wade*, 410 U.S. 113 (1973) in the case of *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), in which the Court held unconstitutional various provisions of the City of Akron's abortion ordinance. The *Akron* Court's clear rearticulation of the analytical framework set forth in *Roe* has provided strong guidance to the courts and a clear message to the state legislatures that laws that substantially burden access to abortion absent a compelling state interest will not withstand judicial scrutiny.

A number of cases involving state anti-abortion laws similar to those at issue in *Akron* and *Ashcroft*, were pending at the time of this Court's decisions in those cases. This Court's decisions provided clear guidance on these statutes and those cases were expeditiously resolved.[60]

---

60 In the aftermath of the *Akron* and *Ashcroft* decisions, a significant number of those cases still pending were resolved through consent decrees and stipulations by the parties. *Bagley v. Wilkinson*, No. C-81-603W (D. Utah Dec. 2, 1983) (stipulation); *Christensen v. Wisconsin Medical Examining Board*, 551 F.Supp. 565 (W.D. Wisc. 1982), (August 1983) (joint motion); *Miks v. Olson*, Civ. No. A3-82-78 (D.N.D. Aug. 25, 1983) (stipulation); *Poe v. Dep't of Public Health*, C.A. 78-C-4126 (N.D. Ill. 1983); *Glick v. Bryan*, CV-R-81-150 (BRT) (D. Nev. Aug. 29, 1984) (consent decree). In the remainder of the cases, the courts held a variety of these laws unconstitutional (*Charles v. Carey*, 579 F.Supp. 377, 579 F.Supp. 464 (N.D. Ill. 1983); *Margaret S. v. Treen*, 597 F.Supp. 636 (E.D. La. 1984); *Eubanks v. Collins*, No. C 82-0360 L(A) (W.D. Ky. Sept. 11, 1984); *Munson v. Meierhenry*, No. 80-3043 (C.D.S.D. Sept. 29, 1983); *Women's Community Health Center, Inc. v. Tierney*, Nos. 79-162 P, 79-165-P (D.Me. Sept. 9, 1983)) while upholding requirements that do "not interfere with physician-patient consultation or with the woman's choice between abortion and childbirth." *Akron*, 462 U.S. at 430.

The Court's strong reaffirmance in *Akron* of *Roe* has apparently been a major force in curtailing the enactment of state laws which unconstitutionally infringe on a woman's right to abortion. In 1979, the year following the passage of the Akron Ordinance, the highest number of abortion-related laws since *Roe v. Wade*—41—were enacted. Legislation patterned after the Akron Ordinance was enacted in 10 states that year.[61] Subsequent to 1979, apparently in response to the repeated failure of these statutes to withstand constitutional challenges, the number of laws designed to limit access to abortion began to decline. By 1982, only 15 abortion-related state laws were enacted.[62] In 1984, only one state enacted a comprehensive anti-abortion statute.[63] The Court's refusal to retreat from the principles established in *Roe v. Wade* and consistently applied in its subsequent decisions has clarified the law for courts and legislatures.

---

61 Donovan, *Fertility-Related State Laws Enacted in 1981*, 14 Fam. Plan. Pers. 63, 66 (1982); 8 *Family Planning/Population Reporter* 77, 92-98 (1979).

62 Bush, *Fertility-Related State Laws Enacted in 1982*, 15 Fam. Plan. Persp. 111 (May/June 1983).

63 The Alan Guttmacher Institute, LEGISLATIVE RECORD, State Legislatures—1984 Bills Enacted (1984).

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the court of appeals from which the appeal is taken. In the alternative, this Court should dismiss the appeal for want of finality, consider the appeal papers as a petition for writ of certiorari and deny that petition.

Respectfully submitted,

NAN D. HUNTER
JANET BENSHOOF
SUZANNE M. LYNN
VERNA C. SANCHEZ
American Civil Liberties
Union Foundation
132 West 43rd Street
New York, New York 10036
(212) 944-9800

Attorneys for *Amici Curiae*

August 27, 1985

APPENDIX A

BOULDER ABORTION CLINIC P.C.
1130 Alpine Avenue
Boulder, Colorado 80302
(303) 447-1361

Warren M. Hern M.D., M.P.H.
Diplomat, American Board of Preventive Medicine
Fellow, American College of Preventive Medicine

28 June 1985

Janet Benshoof
Director
Reproductive Freedom Project
ACLU Foundation
132 West 43rd Street
New York, New York 10036

Dear Ms. Benshoof:

In response to your request for information concerning the use of the dilatation and evacuation (D & E) procedure for abortions past the time of fetal "viability", I can give you three examples in my recent experience.

Before describing these examples, however, I would like to point out that the definition of fetal "viability" is subject to various interpretations and is constantly changing. One definition utilizes a length of gestation counting from the beginning of the last normal menstrual period (LNMP); another way of estimating "viability" is according to birth weight. The classical definition of the first is 26-28 menstrual weeks' gestation. It would be difficult to find anyone, even physicians opposed to abortion, who would contend that a fetus is viable at 24 weeks or earlier, principally because fetal lung development is so inadequate at that stage. It would similarly be difficult to find evidence of fetal viability for individuals with birth weights of

500 grams or less. Above these points, however, there are numerous instances of survival, albeit with severe handicaps. It is questionable whether 500-1000 grams or 26-28 weeks constitutes a lower limit of "viability" because the survival rate is so low, especially outside major neonatal centers.

There being a recognizable percentage of survival of individuals born with weights between 500-1000 grams, however, it is possible to say that abortions by D & E are routinely done at the lower limits of this range. For example, in my paper, "Serial multiple laminaria and adjunctive urea in late outpatient dilatation and evacuation abortion" (Obstet Gynecol 63:543, 1984), I described a series of 1000 patients from 17 through 25 menstrual weeks whose abortions were performed by the D & E method. Twenty of these patients, through preoperative diagnostic error, were at 25 weeks' gestation, with fetal weights ranging up to 906 grams. There were no major complications in this group, and the overall major complication rate for the entire series was 0.3%, demonstrating the safety of the method.

In another paper, "Correlation of fetal age and measurements between 10 and 26 weeks of gestation" (Obstet Gynecol 63:26, 1984), I established recommended values for determining fetal age during that portion of pregnancy. Recommended values for fetal weights for weeks 23-26 were all above 500 grams.

Without searching for extreme examples, therefore, it can be demonstrated that the D & E method can be used for the termination of pregnancies beyond the early stage of viability, at least, with superior safety, aside from the medical indications for abortion in a particular case. The method is fully described in my textbook, *Abortion Practice* (JB Lippincott, 1984).

As for extreme examples, three cases illustrate the utility and safety of the D & E method when abortion is indicated well past the most conservative lower limit of fetal viability.

CASE 1

The patient is a 28 year old woman, a health professional in excellent health, who was found to be carrying a fetus with a lethal defect, thanatophoric dwarfism, at 26 weeks' pregnancy. The pregnancy was desired. The diagnosis was made during a routine ultrasound evaluation. By the time the diagnosis was made and a decision to terminate the pregnancy was made, the patient was past the limit for performance of abortion in her state. She contemplated travel to Japan for abortion. She also contemplated suicide. She was, in fact, severely depressed and suicidal at one point. Thanatophoric dwarfism is a rare condition in which the fetal lungs cannot develop and function normally, principally due to restriction of the thoracic cavity. When the patient was referred to me, she was approximately 30 weeks pregnant. I performed a D & E abortion by the method described in the first paper (63:543, 1984), without serious difficulty. Blood loss was 250cc. Fetal weight was 1247 grams. The patient recovered without incident. The diagnosis of thanatophoric dysplasia was confirmed by histopathologic study of fetal tissues.

CASE 2

The patient is a 24 year old woman, an X-ray technician in excellent health, whose pregnancy was planned and desired. The presence of spina bifida was discovered during a routine ultrasound examination, and a decision was made soon after to terminate the pregnancy. The patient was distraught about the diagnosis but determined with her husband that it would be unwise to carry the pregnancy to term. At the time of her referral, she was approximately 27 weeks from LNMP. Abortion was performed using the D & E method as described in the first paper (63:543, 1984) without difficulty. Blood loss was 25cc. Fetal weight was 1049 grams. A severe neural tube defect was present in the fetus. The patient recovered uneventfully and experienced no complications.

CASE 3

The patient is a 28 year old Native American woman with a history of alcoholism and peritoneal adhesions due to previous complicated abdominal surgery. She was found to be carrying a fetus with severe hydrocephalus at 27 weeks from LNMP. Abortion was performed without difficulty using the D & E method described in the first paper (63:543, 1984). Blood loss was 350cc. Fetal weight was 686 grams. The patient recovered uneventfully and experienced no complications.

While I have not included them here, I have seen numerous other cases of severe fetal deformity in which the method of choice for abortion was the D & E method, but most patients presented themselves for treatment before 24 menstrual weeks' gestation. In one case, a woman was referred from Florida with a a diagnosis of conjoined twins. Aside from the fact that the defect was clearly fatal for the fetus(es), carrying the pregnancy to term would have presented a severe hazard to the woman's life. Any other method of abortion would have resulted in severe risks to her life and, in the case of hysterotomy, a 100% risk of major complication. The abortion was performed by D & E without difficulty and with no complications.

Thank you for inviting be to comment on this issue.

Sincerely,

/s/ WARREN M. HERN, M.D.
Warren M. Hern, M.D., M.P.H.

APPENDIX B

Commonwealth of Pennsylvania
Department of Health

QUARTERLY REPORT OF ABORTIONS PERFORMED

Under Act 209, September 10, 1974 of the General Assembly of the Commonwealth of Pennsylvania, the Abortion Control Act, Chapter 35 P.S. § 6606(e), every facility in the Commonwealth of Pennsylvania in which an abortion is performed is required to file with the Department of Health a report showing the total number of abortions performed within that hospital or facility during that quarter year.

The reporting quarters are:

First — January 1 through March 31
Second — April 1 through June 30
Third — July 1 through September 30
Fourth — October 1 through December 31

A report must be filed, even though no abortions were performed.

Please note the *five* tables included in this report have been revised to give more complete information and to comply with the requirements of the Abortion Control Act. All tables must be completed.

For your convenience, two copies of this form are being sent to you. The original, when completed, is to be returned to the Department of Health, the second is for the facility's records.

Reports are due in the Department within 30 days of the end of the quarter.

Send to:

State Health Data Center
Division of Health Statistics and Research
Pennsylvania Department of Health
Room 126, Health and Welfare Building
P.O. Box 90
Harrisburg, Pennsylvania 17108

QUARTERLY REPORT OF ABORTIONS PERFORMED

Facility Reporting

_____

_____

Quarterly Report for the 1st, 2nd, 3rd or 4th Quarter (circle one).

Person to contact for any questions regarding data _____

_____

TABLE 1

INDUCED ABORTIONS BY TIME

Time Period			Number Of Abortions
Weeks of Gestation	OR	Weeks Elapsed From 1st Day of Last Menstrual Period	
0 - 8		0 - 10	
9 - 10		11 - 12	
11 - 12		13 - 14	
13 - 15		15 - 17	
16 - 20		18 - 22	
21 - 24		23 - 26	
25 +		27 +	
Unknown			
		TOTAL	

TABLE 2
INDUCED ABORTIONS BY TYPE OF PROCEDURE

Abortion Procedure	Number Of Abortions
Suction Curettage	
Sharp D & C	
Intra-uterine Saline Instillation	
Intra-uterine Prostaglandin Instillation	
Hysterotomy	
Hysterectomy	
Other	
Unknown	
TOTAL	

TABLE 3
INDUCED ABORTIONS BY AGE OF WOMEN

Age	Number Of Abortions
10 or less	
11	
12	
13	
14	
15	
16	
17	
18	
19	
SUB TOTAL	
20 - 24	
25 - 29	
30 - 34	
35 - 39	
40 - 44	
Over 44	
Unknown	
TOTAL	

TABLE 4

NUMBER OF CONDITIONS AND COMPLICATIONS OF INDUCED ABORTIONS

NO CONDITIONS OR COMPLICATIONS	
COMPLICATIONS Hemorrhage	
Infection	
Uterine Perforation	
Cervical Laceration	
Retained Products	
Other	
CONDITIONS DISCOVERED Rubella Disease	
Hydatid Mole	
Endocervical Polyp	
Malignancies	
Other	
TOTAL	

TABLE 5

INDUCED ABORTIONS BY RESIDENCE OF WOMEN
(PENNSYLVANIA COUNTIES, STATES OTHER THAN PENNSYLVANIA, OR OTHER COUNTRIES)

PENNSYLVANIA COUNTIES	NUMBER OF ABORTIONS
UNKNOWN	
TOTAL	

STATES OTHER THAN PENNSYLVANIA	NUMBER OF ABORTIONS
New York	
New Jersey	
Ohio	
Maryland	
Delaware	
West Virginia	
Other States	
State Unknown	
TOTAL	
OTHER COUNTRIES (List Name)	
TOTAL	
TOTAL ABORTIONS	

APPENDIX C

STATE STATUTES WHICH HAVE REPORTING REQUIREMENTS

Fla. Stat. Ann. § 390.002 (Supp. 1985); Ga. Code Ann. § 16-12-141(d) (1984 & Supp. 1985); Hawaii Rev. Stat. § 338-9 (Supp. 1984); Idaho Code § 39-261 (Supp. 1984); Ill. Ann. Stat. ch. 81-30, § 10 (Supp. Smith-Hurd 1985); Ind. Code Ann. § 35-1-58.5-5 (Burns 1979 & Supp. 1984); La. Rev. Stat. Ann. § 40:1299.35.10 (Supp. West 1985); Me. Rev. Stat. Ann. Title 22, § 1596(2) (1980 & Supp. 1984-1985); Mich. Comp. Laws Ann. § 333.2835 (1980 & Supp. 1985); Minn. Stat. Ann. § 145.413 (West Supp. 1985); Mo. Rev. Stat. § 188.052 (Supp. 1982); Mont. Code Ann. § 50-20-110 (1983); Neb. Rev. Stat. § 28-343 (1979); Nev. Rev. Stat. § 442.260(2) (1979); N.M. Stat. Ann. § 24-14-18 (1978 & Supp. 1984); N.Y. Pub. Health Law § 4160(2) (McKinney 1977 & Supp. 1984-1985); N.C. Gen. Stat. § 14-45.1(c) (1981); N.D. Cent. Code § 14-02.1-07 (1981 & Supp. 1983); Okla. Stat. Ann. tit. 63, § 1-739 (West 1984 & Supp. 1984-1985); Or. Rev. Stat. Tit. 36, Chap. 435 (1983); S.C. Code Ann. § 44-41-60 (Law. Co-op. 1985); S.D. Codified Laws Ann. § 34-23A-19 (1977 & Supp. 1984); Tenn. Code Ann. § 39-4-203 (1982 & Supp. 1984); Utah Code Ann. § 76-7-313 (Supp. 1983); Va. Code § 32.1-264 (1985); and Wyo. Stat. § 35-6-108 (1977 & Supp. 1985). States without reporting statutes voluntarily report to CDC.

APPENDIX D

STATE STATUTES WHICH REQUIRE CONFIDENTIALITY OF REPORTS

Fla. Stat. Ann. § 390.002(3) (Supp. 1985); Ga. Code Ann. § 16-12-141(d) (1984 & Supp. 1985); Idaho Code § 39-261 (Supp. 1984); Ill. Ann. Stat. ch. 81-30, § 10(12) (Supp. Smith-Hurd 1985); La. Rev. Stat. Ann. § 40:1299.35.10 (Supp. West 1985); Me. Rev. Stat. Ann. tit. 22, § 1596(2) (1980 & Supp. 1984-1985); Mich. Comp. Laws Ann. § 333.2835(4) (1980 & Supp. 1985); Minn. Stat. Ann. § 145.413 (West Supp. 1985); Mo. Rev. Stat. § 188.055(2) (Supp. 1982); Mont. Code Ann. § 50-20-110(5) (1983); Neb. Rev. Stat. § 28-343(10) (1979); Nev. Rev. Stat. § 442.260(2) (1979); N.M. Stat. Ann. § 24-14-18 (1978 & Supp. 1984); N.C. Gen. Stat. § 14-45.1(c) (1981); N.D. Cent. Code § 14-02.1-07(1)(b) (1981 & Supp. 1983); Okla. Stat. Ann. tit. 63, § 1-738(c) (West 1984 & Supp. 1984-1985); Or. Rev. Stat. Tit. 36, Chap. 435 (1983); S.C. Code Ann. § 44-41-60 (Law. Co-op. 1985); S.D. Codified Laws Ann. § 34-23A-19 (1977 & Supp. 1984); Tenn. Code Ann. § 39-4-203 (1982 & Supp. 1984); Utah Code Ann. § 76-7-313 (Supp. 1983); and Va. Code § 32.1-264(b) (1985).

APPENDIX E

WOMEN'S HEALTH CENTER
610 Medical Arts Building, 324 West Superior Street
Deluth, Minnesota 55802 (218) 727-3352

A non-profit clinic for birth control and reproductive choice

August 2, 1985

Janet Benshoof
American Civil Liberties Union
132 West 43rd Street
New York, New York 10036

Dear Janet:

The Women's Health Center of Duluth is one of the many medical facilities providing abortion services throughout the country were staff and patients have come under increasing harassment from anti-abortion activists. Not only have I received disturbing phone calls at my home from these activists, but several incidents in which anti-abortion activists have identified our patients and contacted their homes have been brought to my attention.

One of the most disturbing of these incidents involved a situation in which an anti-abortion activist called the parents of an eighteen-year-old patient several times and told the parents that she (the young woman) had been to our facility and that our facility performs abortions. It appears that the anti-abortion activist identified the patient by her high school sweater through the school yearbook. Because of this disclosure the young woman was thrown out of her parents home and had to drop out of college.

I recently received an angry phone call from the older sister of a young woman who had just had an abortion performed at our clinic. The woman complained that a letter bearing our

address had been sent to the patient's parents' home pleading that she not have an abortion. The letter was signed by a woman known to me as an anti-abortion activist. I explained that the letter was not sent by anyone from the Women's Health Center and a check of the patient's file showed that her parents address was not in the file. Somehow, the anti-abortion activist had been able to identify the young woman and obtain her address.

The patients gave me permission to sent the attached letters.

Sincerely,

/s/ KATHERINE WELSH
Katherine R. Welsh
Executive Director